Health History Form

Participant's Name_____ Birth date _____
Address _____ Apt. _____
City_____ State _____ Zip _____
Parent _____
Home _____ Work _____ Cell _____
Person to contact in an emergency _____
Phone _____
Doctor's Name _____Phone _____

Has the participant had any of the following (please check):

_____Heat Trouble	_____Mumps	_____Tonsilitis
_____Nosebleeds	_____Chicken Pox	_____Appendicitis
_____Fainting	_____Measles	_____Frequent Colds
_____Asthma	_____German Measles	_____Headaches
_____Hay Fever	_____Rheumatic Fever	_____Bed Wetting
_____Sinus Trouble	_____Scarlet Fever	_____Constipation
_____Ear Infection	_____Diphtheria	_____Upset Stomach

IMMUNIZATIONS

Give the year of the last immunization or booster

_____Tetanus
_____Diphtheria
_____Whopping Cough
_____Polio
_____Mumps
_____Measles
_____German Measles
_____Hepatitis A
_____Hepatitis B

Allergies: _____

Bee Stings, mosquitoes, etc. Medication _____

Food (name): _____ Medication _____

Asthma (or hay fever) Medication _____

Serious injuries or illness: _____

Medical treatment during the past year: ____ yes ____ no

Date: _____ Reason: _____

Does the participant take medication? ____ yes ____ no

If "YES," complete "**Request For Medication Form**"

- Prescription Drugs must be in original pharmacy containers.
- Notify adventure leaders if any medicine is brought on the trip.

Permission to dispense Tylenol / ibuprofen: ____ yes ___ no

Remarks: _____

_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT

I (We), the undersigned parent(s) of _____, a minor, do hereby authorize the Directors of the Outdoor Recreation Program as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any position or surgeon, licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being given in advance of any specific diagnosis, treatment, or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing and delivered to said agent(s).

Signature of Parent/Guardian _____ Date:_____

NOTE: The signing of this Consent to Treatment Authorization is requested for your protection.

Return to: 1801 4th St NW 87102-1425